Quality Measures: Care Coordination Tiger Team
Draft Transcript
October 8, 2010

Presentation

Timothy Ferris – Massachusetts General – Medical Director
Welcome to the HIT Quality Measures Workgroup Care Coordination Tiger Team meeting. My name is Tim Ferris. I think we should start off with a roll call. Right, Creagh?

Creagh Milford – ONC
Yes. So far, on the line, we have Tim Ferris, Laura Petersen, Sarah Scholle, Helen Burnstin. We have Andrea Widener from Booz Allen, and we have Alison from Altarum. Is there anyone else on the call?

Timothy Ferris – Massachusetts General – Medical Director
It sounds like that's it. We have potentially four other people on the committee who may join us during the course of the discussion. Creagh, I'm going to ask that you remind me periodically at natural breaks in the discussion to open the lines for public comment. Is that the way we should do this?

Creagh Milford – ONC
Sure.

Timothy Ferris – Massachusetts General – Medical Director
Then why don't we get started? The charge of this committee is to make some prioritization recommendations for measures for the next phase of meaningful use to the HIT Policy Committee, first to the measures workgroup. The order or the process that we have established to make these recommendations includes two-phases. The first phase is to establish priorities within the sub-domains of care coordination. The second phase is to, within those, review potential measures and come to decisions regarding priorities for those measures within the sub-domain. Any questions about that very general description of the process?

Hearing none, we have the results of the committee prioritizations of the sub-domains. Creagh, I'm going to turn to you here. I've got the grid in front of me of the committee members' votes, but I didn't get a summation—or maybe I did, but I don't have it in front of me—a summation of those votes. It wasn't entirely clear to me that everyone answering had similar understandings of what we were to be doing.

Helen Burstin – NQF – Senior VP, Performance Measures
Agreed.

Creagh Milford – ONC
I would agree. At about 1:45, I sent out a PowerPoint slide that should do a graphical representation of the voting results.

Timothy Ferris – Massachusetts General – Medical Director
I'm sorry. I printed all this material out. I'm going to see if I can get online now, but I'm a remote location right now. Would you be able to verbally summarize that?

Creagh Milford – ONC
What we did: We had all of the workgroup members, except for Eva Powell, who provided voting prioritization results, one being the highest, seven being the lowest prioritization for sub-domains. We then prioritized those along the X-axis of a graph. Priority number one: Since we have a very small population of votes, contained communication, effective care plans, care transitions, and having a medical home. In priority two, we had intervention coordination, appropriate timely followup, effective care plans, and care transitions. In priority three, we had, again, intervention coordination, appropriate

and timely followup, care transitions, and having a medical home. That represents on the Y-axis the number of votes per sub-domain.

In summary, the areas that stick out the most from at least the initial results are having an effective care plan is in the top one or two priority areas for people. The sub-domain of care transitions soon to be voted within the top three consistently. Appropriated and timely followup was in the number two, three, and four priority order respectively. In addition, two members put communication as the first priority. I still don't know if that gets us to where we want to be in terms of having a rank order of them, but it hopefully will offer a path for discussion.

Timothy Ferris – Massachusetts General – Medical Director
I think it may well offer a path for discussion. Should we maybe ask the members of the committee a little bit about what they were thinking in order to flush this out a little bit more in addressing these? When I was looking at other people's votes and trying to tie them to my vote, I realized that I probably have a bias in that I was probably prioritizing what I thought was doable in the near future over what was aspirational. I think that dynamic is going to play out throughout our decision making here, so it might be good to have a discussion. But I'd like to hear what other people were thinking about when they were going through their priority list.

Helen Burstin – NQF – Senior VP, Performance Measures
I had a similar pragmatic approach, which is, I was trying to think about, particularly in light of the discussion we had with the broader committee about HIT sensitivity, where I thought there were domains where HIT could really be brought to bear, both in terms of measurement, as well as improvement as being sort of my first priority, as I did the ranking.

Timothy Ferris – Massachusetts General – Medical Director
Anyone else, Laura or Sarah?

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
I also was thinking about practical concerns when I was choosing this, but it wasn't my primary thing, as I voted. I think it did weigh on my decision, but it's probably similar to everyone else.

Timothy Ferris – Massachusetts General – Medical Director
If we were to look at variance in voting rather than consistency, what's interesting to me is a lot of people ranked communication fairly low, but two people, including myself, ranked it high, and with Helen being the middle child. I thought maybe we could discuss that one a little bit because there was sort of dramatic inconsistency, which makes me think that what we were thinking about, of what constituted communication as being, we were probably thinking about different things or potentially. Maybe by starting, I would say that just putting on the table, I ranked communication number one because, in an electronic environment, measuring the fact that communication occurred is a relatively straightforward thing to do, and whereas measuring the content of that communication can be much more complicated.

Measuring the existence of communication, at least to the extent that it uses electrons and computers, can be relatively straightforward. I think that was sort of thinking of communication as a transaction, an electronic transaction was the reason why I, and the fact that a communication transaction is in some ways the basic, one of the basic building blocks of care coordination. I'm not trying to sell anything here. I just want to understand what people were thinking when they were voting, putting down as sort of the lowest priority.

Sarah Scholle – NCQA – Assistant Vice President, Research
I'm one of those folks that did that. I think it has to do with— Actually, part of it was HIT sensitivity, and I also think there's kind of an overlap in the constructs here. I prioritized things like care plans and transitions high because I felt like that HIT could really make those things happen. I actually think communication, when I look at the language that's in communication, I see effective care plan as being a way of accomplishing the communication goal. If communication is being measured by patient perspectives on the quality of communication, I don't think that's directly HIT sensitive, as looking to see if

there's a care plan that's actually given as a way of communicating with patients and with providers. I'm not sure that what we want to accomplish, our goals are different. I just think that we're thinking about these domains differently. I thought communication meant perspectives on communication, or experience ratings.

Timothy Ferris – Massachusetts General – Medical Director
Okay. I think it's not at all surprising. I totally agree with you that because these are all highly conceptual domains, more or less, that we would aggregate different ideas to different concepts or different parts of them. I think you're right, Sarah, that we were probably thinking in terms of our goal consistently, but how we were lumping and splitting things was quite different. Laura, did you have a similar approach to communication?

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
Yes. We've done a lot of work on looking at alerts as a method of communication of lab results to providers in the VA electronic health record. What happens is when you use these very simple things, you assume that you alert a provider about an abnormal test and that they'll do something. The providers aren't necessarily taking action. They're overwhelmed with these communications. So I was kind of thinking about, like Sarah, I guess, of a more sophisticated form of communication. I'm just worried about measuring what's easy to measure about communication and not really getting at what we really want, which is more about doing something important. For that particular one, I was thinking about the practical issue of how it's going to be measured and getting concerned about that.

Helen Burstin – NQF – Senior VP, Performance Measures
Tim, just to add to that, I ranked it sort of middle of the road because I felt like the transactional communication would be measured if you look at care transitions, effective care plans, and appropriate and timely followup. To me, it seemed more mechanistic than actually a domain.

Timothy Ferris – Massachusetts General – Medical Director
Yes. I think that's a good point, Helen, in that when you do measure those other things, you are in fact measuring communication, at least in a really general way. Maybe the communication sub-domain was too general to be useful a grid like this. It certainly seems as though we all approached it somewhat differently or at least enough of us approached it differently.

Then going back to Creagh's assessment that effective care plans, care transitions, and appropriate and timely followup sort of came down as one, two, and three respectively. How does the group feel about that as a— We don't have to beat this to death. I think this should be a method that serves ... end and not an end in itself, so I don't think we need to feel unduly bound by our rank orders, but it's really just a heuristic for coming up with a really good set of measures that does hit the high, the most important pieces of care coordination. With that preamble, how do you guys feel about effective care plans, care transitions, and appropriate and timely followup as the priority ranking of our tiger team? A resounding endorsement.

Sarah Scholle – NCQA – Assistant Vice President, Research
I think we should work with that. Let's go with it and then see what happens when we get the measures and see if some important construct doesn't fit within those.

Timothy Ferris – Massachusetts General – Medical Director
Terrific. Any disagreement with that? All right. Thank you, Sarah. I'm just going to have these … pauses because I just need to make sure that I'm not completely going off the deep end. Thanks, Sarah, for jumping in. Why don't we, Creagh, say that the tiger team is going to use that as our initial construct for approaching prioritization in the sub-domain because I think we're going to move from here to the measures? Maybe this is a moment to open the lines up and ask for public comment.

Alison Gary – Altarum Institute – Communication Technologies Coordinator
You would like to do public comment at this time?

Timothy Ferris – Massachusetts General – Medical Director
That would be great. Thank you.

Alison Gary – Altarum Institute – Communication Technologies Coordinator
Operator, please let us know if any public comments are placed into the queue.

Operator
There are no comments at this time.

Timothy Ferris – Massachusetts General – Medical Director
Well then, let's go on with our work here. I think we're going to move to start thinking about measures and focus on these domains. I'm going to just throw out an idea for a process here. I haven't discussed this with anyone. This is just what I was thinking about before this call. Please, and I know particularly, Helen, you're very good at these processing … since you do it so much at NQF, and you are very much involved with the creation of the Gretzky Report in terms of what a good, systematic process would be for us.

I thought what we might do is use the Gretzky Report that we were, the section of it that we were sent on care coordination, and actually walk through the measures. I know that's less efficient than just asking you guys to sort of shout out your favorite measures, but I think we could do this relatively quickly and talk a little bit about the measures. There's not a ton of them here. I can't count them. Does that sound okay? Does everyone have that in front of them?

Helen Burstin – NQF – Senior VP, Performance Measures
I think it was sent to us.

Timothy Ferris – Massachusetts General – Medical Director
Yes, it was.

Helen Burstin – NQF – Senior VP, Performance Measures
One other suggestion, Tim, as we're going through this, although we had sort of put a measure concept directly related to the NPP goals. One idea might be to actually try to align if it's sort of a measure that resonates with us, maybe actually categorize it into one of the sub-domains.

Timothy Ferris – Massachusetts General – Medical Director
Yes. I think that actually would keep us on track with our heuristic of the prioritization of the sub-domains.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Timothy Ferris – Massachusetts General – Medical Director
With that in mind, as far as I can tell here, and please orient me if I don't have this correct, but on the Gretzky Report that I'm looking at, which is page one of 40, under the care coordination, the top care coordination measure concept priority area is care coordination, medication management, and adherence.

Helen Burstin – NQF – Senior VP, Performance Measures
Right.

Timothy Ferris – Massachusetts General – Medical Director
The first measure within that domain is NQF number 97, medication reconciliation for patients 65 and older. This, in the Gretzky Report, gets high marks right across the board, as in it's ready. It's HIT sensitive. It supports parsimony, preventable burden. It's right across. It's high. Except for supports risk status, which I think is one of those sections, which is sort of what I think of in my mind as a category B type issue.

Helen Burstin – NQF – Senior VP, Performance Measures
More aspirational.

Timothy Ferris – Massachusetts General – Medical Director
More aspirational. Right. So this seems to be, and if I were to just put it in a domain, there was actually a domain that we didn't rank among the top three. I think it probably would have gotten number four, if I look at this, which is intervention coordination, which includes medication management.

Helen Burstin – NQF – Senior VP, Performance Measures
Although one could argue it's a pretty critical care transitions measure as well because it's specifically oriented to medication reconciliation at transition. The only other qualifier I'll have, and Sarah may be able to speak to this since I think it's an NCQA measure, but one thought would be this would be an example of a measure that probably, for broad scale use, might need modification to get at the population beyond Medicare.

Timothy Ferris – Massachusetts General – Medical Director
Yes, which would be a fairly straightforward modification. I'm going to, maybe as a proposal based on the use of the Gretzky Report, I'm going to propose that we rank this, and maybe we'll just come up with an ad hoc ranking scheme right now, a rank that's high, as far as a tiger team prospect for a care coordination measure. Any objections to that ranking? Obviously once we do this, I think we'll get quicker at this. Creagh will help us at the end with a summary, and we can look at our work because obviously when you start off, you're not very oriented to how you feel vis-à-vis the other measures. But we quickly will calibrate with each other, I think, and then we'll be able to see the summation and correct it before our next call.

Sarah Scholle – NCQA – Assistant Vice President, Research
I just want to ….

Timothy Ferris – Massachusetts General – Medical Director
Without any objections to that, we'll go on to the next one.

Helen Burstin – NQF – Senior VP, Performance Measures
I think somebody is trying to get in, Tim. It's a little hard to hear them.

Timothy Ferris – Massachusetts General – Medical Director
I need to pause longer.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
Yes.

Timothy Ferris – Massachusetts General – Medical Director
Anyone want to comment?

Sarah Scholle – NCQA – Assistant Vice President, Research
I think that Helen is correct. This is medication reconciliation after an inpatient event, I'm pretty sure.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Sarah Scholle – NCQA – Assistant Vice President, Research
So it does get at care transitions, so I do want to endorse fitting in that category, and I agree with it being a high priority.

Timothy Ferris – Massachusetts General – Medical Director
Great. That's helpful. I wasn't aware of the transition element to it. The next one is NQF. I'm going to assume, Laura, that you're in agreement with that and that you're safely behind your mute button.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
That's correct.

Timothy Ferris – Massachusetts General – Medical Director
NQF number 542, adherence to chronic medications: This hits high on the state of readiness and high on parsimony, but it gets a medium on HIT sensitive, a medium on preventable burden, and on the aspirational aspects, it's a medium and a low. This doesn't look as good. Does this measure, Helen, require? Yes. Right. It requires, on the right-hand column, the comments. It requires claims data.

Helen Burstin – NQF – Senior VP, Performance Measures
It's actually a completely claims-based measure of pharmacy claims plus diagnostic claims. The second comment there was just something we added in saying, if you think about this in an HIT way, you would also need to consider how those data flow into the EHR if you want to use something other than claims data to retool it.

Timothy Ferris – Massachusetts General – Medical Director
Right. Yes.

Sarah Scholle – NCQA – Assistant Vice President, Research
This is really hard. I think it's aspirational to think about it just because of the challenges of getting pharmacy data into an EHR format. We're thinking about measures that have applied to providers, not to populations or health plans, right? It's challenging….

Timothy Ferris – Massachusetts General – Medical Director
Yes, so I think … a little bit of this, and it is. It's very tricky to do. We can only do it on a subset of our populations, and it's relatively unstable in that we have to get claims and incorporate them. The claims don't always come, and it's proven to be quite a difficult measure for us to do to actually adjudicate claims versus, and find a way to make sure that it's provided to the provider in a meaningful way. So it's definitely an important thing, and we will eventually have the data, I think, to do it, but it's more aspirational. So I wonder if we were— Now we come up with the question of how do we handle that situation where it's a good measure, but we see it as being more aspirational than something that's likely to be implementable the year after next.

So we have two choices. We can either keep a single categorization scheme, I think, of high, medium, and low and just say, if it's aspirational, it's low or medium. I think that may not work because we had this conversation about how we want to make sure we keep some aspirational aspects to our work. It might be better to say, this is a medium, and have a separate designation of aspirational, and just keep track of the aspirational measures. Are we getting too complicated, Creagh?

Creagh Milford – ONC
No, I think that that's good. If I can make one comment, we do have a section at the very end, and just so as members talk about the different measures for methodologic issues associated with each measure. We actually have an entire tiger team devoted to the details of the methodologic issues around the measures. So as you all talk and discuss measure prioritization, if there are methodologic issues that arise, they don't necessarily need to be resolved by this group. But if we bring them to the attention of the ONC, then we can pass those along to the other tiger team.

Timothy Ferris – Massachusetts General – Medical Director
That's very helpful to know, Creagh. Further comments? I would propose we make it following the Gretzky Report leave here a medium and aspirational. I want to keep going. We'll try to keep this moving. Rates of adverse drug events due to contraindicated drugs: state of readiness, medium; HIT sensitive, high, reports parsimony, medium; and then on the aspirational side, it was given high markets. It was developed as part of a research study, similar to e-measures implemented by HRSA. Did you have a comment about this one, Helen?

Helen Burstin – NQF – Senior VP, Performance Measures
Just to make the point that this is definitely one of those measures I think people were interested in. It isn't one of the ones that's endorsed yet, so I think there's probably lots of variations on who this is done by different health systems, and I'd be curious if Laura had insights as to how it's done at the VA, for example. The only question is just in terms of thinking about where we sit at the moment, whether that actually might wind up being something perhaps more in the safety realm.

Timothy Ferris – Massachusetts General – Medical Director
It does … rates of ADEs does seem like a safety thing.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
Yes. I agree with that being a safety measure. The VA has had an interesting approach to this. For their whole safety infrastructure, they haven't ever wanted to do more of an epidemiologic approach to these kinds of events other than looking at numbers of route cause analyses and so forth, and that's been because of Jim Bagian's philosophy as leader of the VA safety. Now he just resigned last Friday, so that may change.

Helen Burstin – NQF – Senior VP, Performance Measures
My goodness.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
Yes. But historically, it's pretty interesting that I couldn't necessarily tell you the total number of these things, which I think I should be able to tell you with all the electronic stuff that we do measure. But it might just be better to delegate that to the safety group. But this is an example of where good coordination across the groups would be important because they may be having the same discussion right now and going, it's really more for coordination … continuity issue. I guess Creagh is going to take charge of that, right, Creagh?

Creagh Milford – ONC
Yes.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
Good. Thank you.

Timothy Ferris – Massachusetts General – Medical Director
Great. Yes, I agree. I think we look at rates of ADEs. We don't, that I know of, sort by ADEs due to contraindicated drugs, and I have a feeling that the numbers might be more in the realm of safety reports and route cause analyses. Again, I don't know, like Laura, don't know the numbers, but I'm not sure that they happen frequently enough to get rates, per se. I think we're going to say that that's a good measure for the safety committee to look at.

Polypharmacy, elderly who consumer ten or more drugs, so this was high for HIT sensitive, medium for state of readiness, and supports parsimony, and medium on the aspirational side. It says implemented in Sweden.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes. We got lists of measures from the U.K. and Sweden, as well as the U.S. We included them here because they were intriguing that we didn't have anything similar, but again, measures that are probably more reflective of the lack, potentially, of coordination around medication use across providers.

Timothy Ferris – Massachusetts General – Medical Director
Yes. As a clinician, I really like the idea of this measure. We have toyed with something similar. We definitely use polypharmacy in the elderly as a risk stratification methodology, but we haven't yet looked

at actually rates, for example. But I don't see any reason why we couldn't or shouldn't. Just to throw something out there, this seems doable to me, and it obviously …. It's very easy to measure at the individual level or provider or group level from an EHR.

Sarah Scholle – NCQA – Assistant Vice President, Research
Assuming you have data from other providers—

Helen Burstin – NQF – Senior VP, Performance Measures
Right.

Sarah Scholle – NCQA – Assistant Vice President, Research
—who were involved in the person's care. It may be relatively easy in your system, but I would imagine there are a fair amount of other kinds of drugs that you're not aware of.

Timothy Ferris – Massachusetts General – Medical Director
Sarah, that's raises the question of, I think there's guidelines that say that at least primary care physicians are supposed to annually reconcile medications and get a comprehensive list. That's part of most annual physicals.

Sarah Scholle – NCQA – Assistant Vice President, Research
Actually, we have a measure too that looks at medication review. One of the challenges is how frequently should it happen, and as we've been revising our patient centered medical home standards, we've been told you can't just say once a year. It's really got to happen at every visit because you have to find out about care that's happened elsewhere that the doctor may not know about. … interesting and useful, but again, like the—but I think it's like the adherence measure is actually aspirational because of the ability of the data sources to really pull data sources. Some people are going to look bad because they have complete data, and people that don't have complete data would look good.

Timothy Ferris – Massachusetts General – Medical Director
Yes. Good point. Maybe a medium in aspirational again?

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Timothy Ferris – Massachusetts General – Medical Director
Great. I'm not sure what the color-coding here is supposed to mean. The next one is a different color.

Alison Gary – Altarum Institute – Communication Technologies Coordinator
This is just the way we did the … report for ONC. We specifically color-coded what was actually endorsed already, what was out there that could be brought in, and what was truly more aspirational. That these were measure concepts people raised for which we did not find any measures either endorsed or in our environmental scan. … just in saying, let's get to adherence measures, but rather than the claims-based approach, we should get it from the voice of the patient. Again, aspirational, no examples were found of where that existed.

Timothy Ferris – Massachusetts General – Medical Director
We might then say, follow along with this and say, adherence to medication. Based on the reading of this state of readiness low, we might say that's from our group's perspective. Our recommendation is low and aspirational.

Sarah Scholle – NCQA – Assistant Vice President, Research
I'm wondering why patient self-report is considered the— I mean, I think that's critical, right, because the patients are the ones who can tell you whether they're really taking their medicines that they've been prescribed.

Timothy Ferris – Massachusetts General – Medical Director

Yes.

Sarah Scholle – NCQA – Assistant Vice President, Research
But it seems like that should be part of, that's going to come up in your adherence to chronic medications measure, which I don't know what it is. If it's just patient self-report without anything else, I'm not really comfortable with that.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Sarah Scholle – NCQA – Assistant Vice President, Research
It's really got to be patients can report on whether they're still using the medications that come off a list from the pharmacy, which is part of what you should check on when the patient comes for a visit.

Timothy Ferris – Massachusetts General – Medical Director
Yes.

Creagh Milford – ONC
Just to cut in briefly, to give the group a little more thought. I talked to Tom Sang yesterday, and we were talking about how the group can also think about measures as being grouped. So if you have a measure that is reconciled on the physician's end, but it could also be reported by the patient. Is there a measure that would be parsimonious enough that could achieve both goals, so just food for thought.

Timothy Ferris – Massachusetts General – Medical Director
Yes, it's a good comment, Creagh. I know that, at NQF, we talk a lot about paired measures, measures that are getting at two sides of the same coin. I think this is a good example of that. You could look at the earlier discussion of the adherence, chronic medication, as being paired with this one. I had proposed low and aspirational. Going once. Going twice.

Helen Burstin – NQF – Senior VP, Performance Measures
Agree.

Timothy Ferris – Massachusetts General – Medical Director
Then generic use measure, so it falls in the same category as you didn't see anything out there, but they thought it had good potential. We actually do measure this at Partners, but we struggle with it because of benchmarks. We don't actually know what great performance is in this because it all depends on what specialty you're in, like what is the goal. The goals vary depending on what you do clinically because that determines what the percent of all of your potential prescriptions that could be generic is determined by your clinical activity. So it's tricky, and we do it on a quite rolled up basis, but it's very difficult to do it at a more granular level.

Sarah Scholle – NCQA – Assistant Vice President, Research
We've looked at this as a measure concept and, I think, struggled with the same issues that Tim is suggesting here. I think where we're addressing it is through standards or structural measures that look to see whether people are actually looking at what's available, have access to what generics are available and whether there are reminder systems to use them. I'm not sure that you could really use this kind of rate to know whether things are getting better.

Timothy Ferris – Massachusetts General – Medical Director
Low and aspirational again. I'm going to keep moving here. I want to sort of make sure that we can get through this. NQF number 496, emergency department throughput, admitted patients, medium time from ED arrival to ED departure for discharged patients. This is an NQF endorsed measure. Its HIT sensitivity is medium, but it's otherwise in place. This is one of those that could be a companion measure with 497 and 497, admitted patients decision time to ED, department for admitted patients.

So I'm just going to ask, for my own edification here. A lot of EDs now, they automatically make you an ED boarder, so you're technically admitted six hours after a bed request has been made, which sort of would make 497— It wouldn't be measuring anything, or am I misunderstanding this? If for example an ED had a rule that you're simply are admitted, if you've been waiting six hours for a bed, which is what most of the hospitals in Boston do.

Helen Burstin – NQF – Senior VP, Performance Measures
yes.

Timothy Ferris – Massachusetts General – Medical Director
Then I'm not sure this measures anything.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes. I don't recall, Tim. I'll have to look up the specs of how they handle patients, whether admitted meant you left the ED or you were physically. I think it's actually admission decision time.

Timothy Ferris – Massachusetts General – Medical Director
Yes.

Helen Burstin – NQF – Senior VP, Performance Measures
So … patients would likely still be included, but I think the broader issue is, is it useful to think about measures of throughput if you actually had the capacity in your IT systems to track timing as a representation of the level of coordination and throughput more broadly.

Timothy Ferris – Massachusetts General – Medical Director
Yes.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
I think, just as part of the measuring process, what is needed is some sort of monitoring to insure that any gaming that's being done or anything like that, so that's what the VA does a lot is it does these audits. It looks for evidence that the real intent of the measure is being fulfilled because people will always game it, but you want to design the measure so that the gaming actually achieves something that you want rather than something that's counter to the intent.

Timothy Ferris – Massachusetts General – Medical Director
Yes. This strikes me as quite doable. We measure this in all our EDs. It sounds like a lot of people do. It's an in-place measure. It's a little less than perfectly HIT sensitive, but it certainly has some HIT sensitivity. I don't think this is an aspirational measure. This is a measure that's doable. The question then is, is it a high or a medium with respect to our framework. I'm sort of in the middle of that and would welcome any.

Sarah Scholle – NCQA – Assistant Vice President, Research
What's the argument for it being high?

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Timothy Ferris – Massachusetts General – Medical Director
I guess the fact that it's pretty limp. It's just that it's a high state of readiness and supports parsimony. I'm really just following the grid that ….

Sarah Scholle – NCQA – Assistant Vice President, Research
Yes, but is it really going to …?

Timothy Ferris – Massachusetts General – Medical Director
Yes. Is it going to change care?

Helen Burstin – NQF – Senior VP, Performance Measures
Right.

Sarah Scholle – NCQA – Assistant Vice President, Research
Yes.

Helen Burstin – NQF – Senior VP, Performance Measures
Part of what we really looked at when we did the preliminary rankings was really, is there any evidence as well that having this kind of information would change care. It, again, seemed more aspirational. If you had it, it might help, but there wasn't a lot of evidence that it'd been tried and true in the same way as some of the others.

Timothy Ferris – Massachusetts General – Medical Director
Yes. I guess I would say we pay a lot of attention to it. It's on our board level dashboard because nationally it's waiting around an ED is a problem.

Helen Burstin – NQF – Senior VP, Performance Measures
Right.

Timothy Ferris – Massachusetts General – Medical Director
I'm happy to go with medium.

Helen Burstin – NQF – Senior VP, Performance Measures
I think it's probably still medium.

Timothy Ferris – Massachusetts General – Medical Director
That was ED throughput. I'm now to NQF 228, care transition measure … CTM three-item survey. I'm unfamiliar with this measure.

Helen Burstin – NQF – Senior VP, Performance Measures
I'm happy to fill it in. This is Eric Coleman's measure. It's a three-item patient survey that gives— It's really a remarkable short survey that gets at sort of patient's comfort level about transitions and use of medications in particular. There are only three items. It's been very, very well tested, excellence evidence out there in terms of impact on care. I think we put in the comments here, it's already been adapted for patient self-report via Web or portal. So if you wanted one that came from the voice of the patient, it seemed like a really likely one to consider.

Sarah Scholle – NCQA – Assistant Vice President, Research
Helen, when are the patients surveyed?

Helen Burstin – NQF – Senior VP, Performance Measures
After discharge. I can pull it up and tell you how soon after. I think it's just within a couple days of discharge.

Timothy Ferris – Massachusetts General – Medical Director
Great. Yes. We're doing this. I actually was unaware of this, as these things go, and we have a brief survey that we're now piloting, often trying to make sure it's been consistent with this, that's different than age caps that gets directly at the quality of the transition.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Timothy Ferris – Massachusetts General – Medical Director
Why was it rated high on HIT sensitivity?

Helen Burstin – NQF – Senior VP, Performance Measures
I think because of the idea that it's already been enabled as a patient Web or portal based measure. It seems, if you have that information very quickly after discharge that somebody didn't know what they needed to do, it seemed like it'll be a logical thing to see, logical expectation that it would drive improvement.

Timothy Ferris – Massachusetts General – Medical Director
Right. It seems to me, based on the Gretzky Report reading of this, and it certainly gets at a fundamental thing that we rate it highly, which is care transitions. That was number two on our priorities, that this would be a high.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes. Just let the folks know, if they'd like to hear, it's like the first item is the hospital staff took my preferences and those of my family into account … my needs when I left the hospital, I had a good understanding of the things I was responsible for in managing my health, and I clearly understood the purpose for taking each of my medications, so very tight. It got … and all that kind of good stuff. The timing is at least 48 hours after discharge.

Timothy Ferris – Massachusetts General – Medical Director
That sounds great. I'm proposing high for that one. Unless I hear otherwise, we'll keep going.

Sarah Scholle – NCQA – Assistant Vice President, Research
That would obviously go under transitions, Tim?

Timothy Ferris – Massachusetts General – Medical Director
Yes. That was transitions. Transition record: So 647, transition record with specified elements received by discharge patients: inpatient, discharge to home, self-care, or any other site of care. This again got high marks across the board, was recently endorsed by NQF. We measure this at partners. I'm not sure if we measure exactly this, but it's certainly very important to us. Again, I think this seems like a high, I would propose.

Helen Burstin – NQF – Senior VP, Performance Measures
Agree.

Sarah Scholle – NCQA – Assistant Vice President, Research
I agree.

Timothy Ferris – Massachusetts General – Medical Director
NQF 648, timely transmission of transition record. Did I just do that one?

Helen Burstin – NQF – Senior VP, Performance Measures
They're sort of companion measures, Tim. Inpatient to home, ED to home, and then ….

Timothy Ferris – Massachusetts General – Medical Director
Yes. Okay. I think we'll just put all three of those as high. Obviously we'll sort through this later when we see what we've done, what damage we brought, but I'll just propose that all those be high. Critical information included with PCP request for specialist referral: state of readiness, medium, HIT sensitive high, supports parsimony, medium, NCQA measure, develop EHRs and ready for submission. Sarah, did you want to make a comment about this one?

Sarah Scholle – NCQA – Assistant Vice President, Research
Actually, this is a whole series of measures, so rows 25 to 30 all fit together looking at coordination between primary and specialty care outpatient focus. It's similar to looking at the transitions, but it's focused on what's happening in the outpatient setting. Actually, this is jointly owned by Hopkins, Park Nicollet, and NCQA. We've worked with Jonathan Wiener and his team and others … to develop the

measures. We have the specifications. We've done some preliminary feasibility work, but they're not specified for electronic records, but ready for that kind … testing.

Timothy Ferris – Massachusetts General – Medical Director
That's terrific. I look forward to that because they look like things that we would love to implement at Mass General and Partners. It seems like these really touch on the key elements that I was thinking about in terms of transactional communication, so I would rate these very highly or high under our scheme. Are there meaningful distinctions to be made? There are six here among the six, or can we treat them as a class?

Helen Burstin – NQF – Senior VP, Performance Measures
I think they're a group.

Timothy Ferris – Massachusetts General – Medical Director
Yes. They look like it to me. I guess I would propose that we maybe rate them high, but there's maybe an asterisk on readiness because they're not e-specified.

Helen Burstin – NQF – Senior VP, Performance Measures
Although many of these others aren't either.

Sarah Scholle – NCQA – Assistant Vice President, Research
Agreed.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes, they just haven't been submitted to NQF yet, but they sound pretty ready.

Timothy Ferris – Massachusetts General – Medical Director
I think it sounds to me like they would be pretty ready too, so why don't we propose that we'll put them in the hopper for this first round as recommended for a high priority?

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Timothy Ferris – Massachusetts General – Medical Director
Plus we just took six off in one swoop. Care coordination, reduce hospital readmissions, so into the next section, NQF number 330. Thirty-day all cause risk standardized readmission rate following heart failure hospitalization.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes. This is just the whole series of heart readmission measures we have, some of which are condition specific in the Medicare population, one of which is broader. But again, there are other things out there under … as well.

Sarah Scholle – NCQA – Assistant Vice President, Research
My question is, isn't there an efficiency cost group, and would these fit better in that group, or do they fit—? I mean, readmission is clearly an outcome of poor coordination. But it looks a lot like waste. So I tend to put it in that bucket rather than in this because it's really the outcome of poor coordination rather than what we've been talking about so far, which they're more measures of processes and care coordination.

Helen Burstin – NQF – Senior VP, Performance Measures
Right. We really view this as an outcome of care coordination, which is why it's actually one of the explicit NPP goals under care coordination to reduce readmissions.

Timothy Ferris – Massachusetts General – Medical Director
Yes. This is an interesting one. I guess we'll turn to Creagh because, in addition to the point you just made about it, it may be falling under another group. It's been sort of top of the list of opportunities to

decrease costs or near the top is the readmission issue. It also has this issue of, it's ranked as low under HIT sensitive here. My expectation for that ranking, Helen, is that it's not exactly clear that you would be pulling elements from an electronic source in order to construct this measure. Now are electronic sources necessarily involved in the remediation of the improvement efforts.

Helen Burstin – NQF – Senior VP, Performance Measures
Right. Not yet. I mean, that's one of the issues, right? If you actually had a fully interoperable HIT system where readmission rates could be gathered across disparate hospitals within a region, it does change it and make it much more actionable.

Timothy Ferris – Massachusetts General – Medical Director
Right.

Sarah Scholle – NCQA – Assistant Vice President, Research
The care transition measures actually are the first step, right?

Timothy Ferris – Massachusetts General – Medical Director
Yes.

Sarah Scholle – NCQA – Assistant Vice President, Research
In some ways you're addressing it, so if it goes anywhere, it's aspirational, long after we've figured ….

Timothy Ferris – Massachusetts General – Medical Director
I think it definitely gets the aspirational flag, and then the other thing we want to know is just the shout out to Creagh to say, is this being addressed? Are readmission measures being addressed under the … tiger team?

Creagh Milford – ONC
I know that they talked about it. Let me get back to you on that, and I can e-mail the group.

Timothy Ferris – Massachusetts General – Medical Director
Great. In general, though, I would say, gosh, yes, they're very important. All right. Should we then move to the next concepts? Care coordination, preventable emergency department visit, the first one is preventable ED visit, general or condition specific. State of readiness is low. I'm just going to read their comment. Environmental scan did not find measure in use. Measure develop needed, AHRQ modifying preventable hospitalizations. Interestingly, Helen, about three years ago, I modified the preventable hospitalizations to look at ED visits, and we do track this in Partners, but we just made up our own thing.

Helen Burstin – NQF – Senior VP, Performance Measures
Right, and I've been told that AHRQ is now attesting converting some of the preventable hospitalization measures and preventable ED measures. Ryan Mutter is working on that work at AHRQ, so there's stuff that's emerging, but we certainly don't have it in our hands yet.

Timothy Ferris – Massachusetts General – Medical Director
Yes. It's probably going to be, in terms of the HIT sensitivity, it's going to be because of the same issue with the readmissions, isn't it likely to be better, as a claims-based measure, at least for the foreseeable future?

Sarah Scholle – NCQA – Assistant Vice President, Research
I think that's right, Tim. I also kind of wonder why we're pulling out preventable ED visits without looking at preventable hospitalizations. Did I miss that in this list? I was talking with one of our staff who has been working on our measures because we're going to be reporting for the first time on hospital readmission measures for Medicare next year, and we're developing a measure for ambulatory care sensitive admissions. I think of those as being in this broad category of avoidable hospitalizations. I guess you could extend it to avoidable ED visits. Again, I tend to think of that as waste and a cost measure.

Timothy Ferris – Massachusetts General – Medical Director
Yes. Creagh, we're giving you a long list of things to do here, but maybe also look at the preventable ED visits and preventable hospitalizations. Are they being handled under the cost reduction tiger team, and even if they aren't, well, I guess we would have to rank them … hear back about that.

Sarah Scholle – NCQA – Assistant Vice President, Research
My thought is that they're aspirational. It makes sense that these data come from claims data, but the aspirational part of it is how do you get the claims data integrated with providers who are responsible for caring for these patients so that it's in their record and available to them. That's clearly aspirational, but a huge issue and a high priority.

Timothy Ferris – Massachusetts General – Medical Director
Right. Agreed.

Sarah Scholle – NCQA – Assistant Vice President, Research
I'm not sure that we're looking to get measures out of EHRs to look at these things. We're looking to how you can take information from claims data about these events and make it available to clinicians in real time so that they can have some affect on care.

Timothy Ferris – Massachusetts General – Medical Director
Right. It doesn't look at, though, that. So in terms of the state of readiness, that would be a low.

Helen Burstin – NQF – Senior VP, Performance Measures
I agree.

Sarah Scholle – NCQA – Assistant Vice President, Research
Agree.

Timothy Ferris – Massachusetts General – Medical Director
The next one, return to ED within 72 hours with the same chief complaint resulting in an admission.

Helen Burstin – NQF – Senior VP, Performance Measures
… measure.

Timothy Ferris – Massachusetts General – Medical Director
This is state of readiness medium, HIT sensitive high. This is one we do at Mass General. We actually do it at the individual doctor level. It's interesting, Helen, that you ranked it high on HIT sensitivity.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Timothy Ferris – Massachusetts General – Medical Director
I guess this is because we have the administrative systems to construct the measure.

Helen Burstin – NQF – Senior VP, Performance Measures
Also, I think part of the reasoning there was that if you actually had this information on somebody returning, you would have the capacity to be able to intervene.

Timothy Ferris – Massachusetts General – Medical Director
Yes.

Helen Burstin – NQF – Senior VP, Performance Measures
If you're on a system.

Timothy Ferris – Massachusetts General – Medical Director

Right, and I'd imagine that you classified it under care coordination because if the discharge from the ED was, you know, it's partially effective care. Did you make the right decisions in the ED? But it's also the coordination with what happened after the ED that does or does not result in representation to the ED.

Helen Burstin – NQF – Senior VP, Performance Measures
Right. Again, part of the reason this is here, as it's stated, and also to respond to Sarah's question is that those were two of the goals under the care coordination national priorities from NTP, so I think … as appropriate.

Timothy Ferris – Massachusetts General – Medical Director
Sarah, did you want to say something?

Sarah Scholle – NCQA – Assistant Vice President, Research
No. I do think these are important. I just think I'd list them as highly aspirational. Not just aspirational, but actually this one is less aspirational, I gather, but the others ….

Timothy Ferris – Massachusetts General – Medical Director
Yes. I agree. Maybe we'll put this down as a medium, maybe a medium in aspirational.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
I think so.

Timothy Ferris – Massachusetts General – Medical Director
Are you following along with us, Creagh?

Creagh Milford – ONC
Yes.

Timothy Ferris – Massachusetts General – Medical Director
Palliative and end of life care, while we, just to remind the group, we generally ranked this low on our sub-domain prioritization, but that was because we felt that it was a particular case of the other things like effective care plans, care transitions, appropriate and timely followup. That shouldn't dissuade us from wading into palliative end of life care measures, in fact, quite the opposite. We have three measures under this listing. NQF 208, family evaluation of hospice care survey, high state of readiness, low HIT sensitive, and low for supporting parsimony. Obviously it's a survey measure.

Helen Burstin – NQF – Senior VP, Performance Measures
Survey, right.

Timothy Ferris – Massachusetts General – Medical Director
I sort of view this as low because the HIT sensitivity. Is that not the right way to think about this?

Helen Burstin – NQF – Senior VP, Performance Measures
To a certain extent, it's going to be difficult. I think the thinking is there's probably a whole lot more that has to happen to get palliative of care to happen than to have these kinds of measures built into IT.

Timothy Ferris – Massachusetts General – Medical Director
Right.

Helen Burstin – NQF – Senior VP, Performance Measures
But I don't know.

Timothy Ferris – Massachusetts General – Medical Director
I would say medium to low, but it's not aspirational in the sense that it is ready. It's aspirational in the sense that it's built into IT systems.

Helen Burstin – NQF – Senior VP, Performance Measures
Right. It's not. Yes. It's a patient survey. Correct.

Timothy Ferris – Massachusetts General – Medical Director
Right. I don't know what comfortably dying is. Well, I can imagine, but I don't know what the measure is.

Helen Burstin – NQF – Senior VP, Performance Measures
I believe it's pain free, etc., within the last days of life, but I'll pull it up.

Timothy Ferris – Massachusetts General – Medical Director
Okay. We'll look at NQF 210, proportion receiving chemotherapy within the last 14 days of life, emergency room visit in the last days of life, more than one hospitalization in the last 30 days, admitted to the ICU, so it's a high state of readiness. It looks like it's lacking in measure steward, but it's an NQF endorsed measure.

Helen Burstin – NQF – Senior VP, Performance Measures
It actually does have a steward, and those are actually four separate measures.

Timothy Ferris – Massachusetts General – Medical Director
Okay. Well, I know we look at two of them, and I think they're very important, and they definitely reflect on— I think, a good reflection of care coordination.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
Which of the two do you look at, Tim?

Timothy Ferris – Massachusetts General – Medical Director
The chemo and lab 14 days, I think that's a UHC measure, and more than one hospitalization in the last 30 days.

Sarah Scholle – NCQA – Assistant Vice President, Research
How do you get the information for those measures, Tim?

Timothy Ferris – Massachusetts General – Medical Director
We just use our own internal system. If they get hospitalized outside our system, then we don't know about it.

Creagh Milford – ONC
Tim, are these already for patients who have decided that they want no more intervention?

Timothy Ferris – Massachusetts General – Medical Director
Correct. The designation as receiving the hospice benefit is the denominator.

Helen Burstin – NQF – Senior VP, Performance Measures
These might be somewhat more analogous to what we're thinking about readmissions or sort of examples of reflection of what didn't happen well when coordination wasn't done. But I guess, do they fit into our high ranked domains? I'm not sure.

Daniel Green – CMS/HHS – Medical Director
Helen, I think your comment earlier in terms of, we have a lot more to do with palliative care before setting them into HIT was right on the numbers.

Timothy Ferris – Massachusetts General – Medical Director
Yes. They marked these as medium or low and aspirational.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes, I think so.

Timothy Ferris – Massachusetts General – Medical Director
Okay.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
I'm sorry if Jim's not on, Jim Walker. He ranked them, palliative relatively high. I was curious what his thinking was, but …. All right.

Timothy Ferris – Massachusetts General – Medical Director
Jim, first of all, thanks for joining us.

Creagh Milford – ONC
I think that's Dan Green.

Timothy Ferris – Massachusetts General – Medical Director
Is it Dan?

Creagh Milford – ONC
Yes.

Daniel Green – CMS/HHS – Medical Director
I've actually been on for about 25 minutes, but trying to figure out which document you were on.

Timothy Ferris – Massachusetts General – Medical Director
I'm sorry. Are you there now?

Daniel Green – CMS/HHS – Medical Director
I'm there.

Timothy Ferris – Massachusetts General – Medical Director
We had a discussion about sub-domains and our prioritization of them. Dan, you and I were the only ones who ranked communication number one. But we talked through what each of us was thinking when we were ranking them and came up with a categorization scheme or prioritization scheme for them, but I think we felt relatively comfortable with knowing that it's really just a heuristic to allow us to frame our discussions and that we don't need to be bound by it. As you can see, we're actually just walking through the coordination measures, and we got to palliative end of life care.

Daniel Green – CMS/HHS – Medical Director
Did we get voted down on our first choice in terms of priority?

Timothy Ferris – Massachusetts General – Medical Director
I think, Dan, it turned out that—and please, others, tell me if I misrepresented our conversation—but I think what other people were thinking when they ranked it low was that it was a really broad and general category. It was either that it was a really broad and general category and, therefore, the specific cases of appropriate and timely followup, effective care plans, and care transitions, what we would be measuring within those is communication, but it was those specific areas that had the priority. The others were thinking that communication actually meant communication from the patients, the patient's experience, and that that was not, I guess, particularly HIT sensitive.

Daniel Green – CMS/HHS – Medical Director
Honestly, I was thinking about communication between physicians caring for the same patient.

Timothy Ferris – Massachusetts General – Medical Director

Yes. That's exactly what I was thinking about too is— Were you the one who said on the last call, communication as a transaction?

Daniel Green – CMS/HHS – Medical Director
I don't think so, but I wouldn't disagree with the statement.

Creagh Milford – ONC
That was David Kendrick.

Daniel Green – CMS/HHS – Medical Director
I've often said this even about our quality measure stuff. To the extent that we can encourage communication and interoperability as a byproduct of advancing some of this measure reporting, that will be, I think, far superior even to, don't hit me, Helen, but to any of the measure stuff that we're doing in terms of reducing duplicate tests and also providing timely care and improving care in general.

Sarah Scholle – NCQA – Assistant Vice President, Research
I'm the one who was arguing that communication was really part of some of the other measures. Part of my thinking is that some of the measures that look at care transitions are really looking at the exchange of information, and then measures that get at the concept of an effective care plan look to see whether there was a meaningful attempt to put that information into action in a way that's shared with the patients and families and reflects what's going on in all the different providers that are caring for the patient. I saw communication as the goal of some of the other factors, so I didn't think it needed to be called out separately.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes. I agree. The other thing that might be helpful is for us to maybe have you and Tim tell us what kinds of measures you were thinking of under the communication domain that wouldn't fit into care transitions, care plans, or timely and appropriate followup.

Daniel Green – CMS/HHS – Medical Director
I'm at a loss right now for the exact measure, but I know there's actually some of the osteoporosis measures, communication, the patient suffers a fracture, and communication with the primary doc taking care of the patient, perhaps to start a disphosphonater, at least … for osteoporosis. I'm trying to think. There's another measure in terms of communication with the primary ….

Helen Burstin – NQF – Senior VP, Performance Measures
Yes. There's a diabetic ….

Daniel Green – CMS/HHS – Medical Director
… there's the diabetic retinopathy to make sure that the person taking care of the diabetes has communication from the ophthalmologist or optometrist. A lot of those things are not currently happening. People are so busy in their office, they're just seeing the patients. The primary care docs often don't get this information, and I think it's important. It works both ways. It's not just the specialist to the primary care, but I can't think of examples of primary care going to the specialist in terms of measures, but the communication, I think, unfortunately is lacking, except … large institution like a GW or Johns Hopkins where you're all on the same system, or Kaiser, where they can pull up all the notes pretty easily.

Helen Burstin – NQF – Senior VP, Performance Measures
Right.

Timothy Ferris – Massachusetts General – Medical Director
It's interesting, Dan. I completely agree with you. When is saw the NCQA measures here on the prior page, page 2 of 40 under the care transitions, those NCQA measures are exactly what I was thinking about when I was thinking about communication. I think we, as a group, I don't know if you were on the call then, Dan, but we ranked them all as high in terms of our prioritization.

Daniel Green – CMS/HHS – Medical Director
Yes. Certainly, I don't mean to sign in 50 minutes after the call starts and trying to derail all the progress that you guys made, but I appreciate the opportunity nonetheless to put my two cents in.

Timothy Ferris – Massachusetts General – Medical Director
Good. Certainly, Dan, when we produced the subsequent spreadsheet that we'll have our prioritization, that's what I expect we will talk about on our next call is sort of sort through whether or not we can, and we'll have a chance to reprioritize once we come with the straw man proposal.

Sarah Scholle – NCQA – Assistant Vice President, Research
I have a question about those. One of the things, as I've been thinking about care coordination, is trying to see it as something that's not—in thinking about a way that we could frame measures so that they're not specific to one population, one disease, but thinking of them as a crosscutting measure that would get at multiple conditions and would apply broadly to patients. I'm kind of curious whether Tim and David, I think, is that you who was just speaking, whether you think that that kind of crosscutting approach makes sense.

Timothy Ferris – Massachusetts General – Medical Director
Sarah, you were sort of cutting in and out a little bit for me on that. I think I heard what you said despite that about the crosscutting. I see, for example, the NCQA measures that we looked at, unless I'm misunderstanding what they are, as being very crosscutting. They're not condition specific. Then I heard Dan talk about the diabetes and the osteoporosis, which are condition specific because they reflect situations in which it's actually very important to have communication, but that situation is pretty clinically specific. So in that context of that … position, could you repeat what you were asking?

Sarah Scholle – NCQA – Assistant Vice President, Research
Yes. I'm sorry about that. It's just Internet connection …. But my question is, I wonder if you could think about the care transitions measures of the care plan measures as being a way to capture the information. Did the information get back? Did it get used in updating a care plan? But then applying it to different patient populations who were at particular risk, you could apply it overall, but you could also think about, well, who is most likely to have this problem when sharing information.

Daniel Green – CMS/HHS – Medical Director
Please don't misunderstand. I was just trying to give some examples of some of the measures that are currently available. I think there are probably not measures available for certainly more broadly applicable measures. But I can tell you, as an OB/GYN, I can't tell you actually how many times I sat there the morning of the surgery trying to wait for the primary's office to fax over the labs or the H&P, and the nurse is going, you're going to derail our schedule. We're just going to repeat the CBC and the pregnancy test, which obviously is a waste of resources. But there is no measure that I'm aware of that measures that kind of communication between practitioners. I was, before, just trying to use examples that already exist, but I don't disagree, Sarah, with what you were just mentioning.

Timothy Ferris – Massachusetts General – Medical Director
Great. Sarah, if we were to, while I agree with what you were saying, I'm struggling with how to operationalize it for us.

Sarah Scholle – NCQA – Assistant Vice President, Research
I guess what I would say is that is the value of care coordination measures is that they could apply generally to people who experience an event like people who are discharged from hospitals, people who see a specialist, people who get care in a hospital or ED. You want to have the information exchange to happen, and you want the information to come back. Generally, you can specify those measures to apply to anybody who is eligible who has that defining event. But you could also think about applying those measures to more narrower populations, so you'd want to stratify. I guess that's what I'm thinking of it as stratification.

Timothy Ferris – Massachusetts General – Medical Director
Yes.

Sarah Scholle – NCQA – Assistant Vice President, Research
Let's look at this for people with diabetes because those are the people that— Is it valuable to look at it generally? In fact, you probably need a sample size. You need the numbers for your sample size for some purposes. But to know where the problems are or to look at specific conditions, it may be useful to say, let's look at people with diabetes, or let's look at pregnancy or availability of information at pregnancy or something like to try to understand where the problems are.

Timothy Ferris – Massachusetts General – Medical Director
I really like that comment, Sara, and I have a proposal for the group for how to work that into our process. Once we come up with our measures, if we—but prior to sort of shipping them off to the main committee--look at them through the lens of whether or not certain subgroups for stratifying these measures might be particularly … the measures, and the ability of the measures to improve care might be particularly strong in certain groups. The reason why I really like that, Sarah, is we're looking at some care transitions inside of our hospital, transitions from one unit to another.

We've recently decided that the measurements burden was too great to measure it everywhere. We needed to go where we thought they would be most useful. We picked up on several categories of patients where we thought measuring care coordination between a point of transition would be very useful or more useful for that group than done broadly. I think we could apply that thinking to our proposed measure set prior to shipping it off, and it wouldn't be that onerous an exercise. In fact, in a weird, geeky sort of way, I would think it's sort of fun.

Sarah Scholle – NCQA – Assistant Vice President, Research
I agree, in that same weird, geeky way, but I do think that it also gets around the bind of really narrowly specified measures. That's one of the things that we're constantly worried about and really trying to rethink our approach to measurement so that we're not facing small numbers all the time. But it also allows flexibility for one organization to say, you know, my problem with hospital readmissions is here. Or my problem with duplicate testing is here, so I want to focus my measurement in this group. I think that sort of flexibility is important.

Timothy Ferris – Massachusetts General – Medical Director
Yes. Great. Should we move to the overuse here? Now this overuse obviously immediately raises the question we had raised before, which is, why is this under care coordination? Why isn't this under waste? Maybe what I would propose is for the time being, we should just look at these three measures, and then we'll hear from Creagh again about whether or not these are. I think, if the other group is using the Gretzky Report, then these measures will not have fallen to them. But I'm not sure they're using the Gretzky Report the same way we are.

Helen Burstin – NQF – Senior VP, Performance Measures
Actually, overuse, I don't believe overuse was included in care coordination before, either was palliative, so this must already be somewhat modified. Yes, so I wouldn't worry about that. Overuse is overuse. I don't really see those necessarily as being coordination issues, at least the unnecessary use of antibiotics in particular. I think they seem misplaced there.

Timothy Ferris – Massachusetts General – Medical Director
Right. That doesn't seem like care coordination.

Helen Burstin – NQF – Senior VP, Performance Measures
No.

Timothy Ferris – Massachusetts General – Medical Director
I think we're going to make an executive decision on those three measures to say those are not care coordination, so we would prioritize them as low, if we had to prioritize them.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes.

Sarah Scholle – NCQA – Assistant Vice President, Research
Agree.

Timothy Ferris – Massachusetts General – Medical Director
The rest of the page here, I think, is different. So that's not under our purview. This is the point at which I need some assistance in terms of our process. Helen, have we exhausted? There are a lot more pages in this handout. Are the other pages in this handout, do they have care coordination measures in them that are different than the ones that we just looked at?

Helen Burstin – NQF – Senior VP, Performance Measures
Again, we tried to put the crosscutting measures listed under care coordination. If you look at the leading condition ones, for example, there are some measures about plan of care for specific conditions or a couple with communication measures that Dan just mentioned for diabetes and a fracture, for example. I'm just not sure it's worth— I mean, we could certainly go through it on our own. I'd actually be curious to know, based on what we just did, how many measures wound up being in which domains because I'm a little fearful that we've now ranked a set of high ranking domains for which we actually don't have measures for most of them, unless I'm missing something.

Timothy Ferris – Massachusetts General – Medical Director
No, I think you're right. I think you're right. Sarah?

Sarah Scholle – NCQA – Assistant Vice President, Research
I agree. I think that one of the areas that we don't have measures for is effective care plans.

Helen Burstin – NQF – Senior VP, Performance Measures
Right.

Sarah Scholle – NCQA – Assistant Vice President, Research
Right? Except when you see some examples here in the condition specific ones. We actually have tested a measure for children for looking at an updated care plan, and in the current environment, it's really impossible. But EHR HIT actually provides a tremendous opportunity to standardize something that you can't pull from chart reviews retrospectively done when people are documenting things in all kinds of different ways. I think there is a need for a measure that is a care plan. It would probably need to fit in with some of these disease specific kinds of measures, and you'd need to think about how it fits with the visit summary concept.

When we did the work on the measures that we talked about earlier on information exchange and the ambulatory care coordination between primary care and specialty care, our advisory panel told us, get the information across first. We'll worry about how it's incorporated into an updated care plan later because they thought that that information exchange part was so hard to do. I actually think that, given where we are today, there's really a critical need to specify what that care plan should look like because if we don't create the measure that says these are the components, and these are the things you expect to have for these kinds of patients, that we're going to miss a great opportunity to build that into the infrastructure.

It is complementary to the existing meaningful use requirement for a visit summary, but it's different. So, like I said, I think we have tested a measure and decided it wasn't ready for prime time, so we didn't actually submit it to NQF under the child health measures call, and we think that it's feasible. We know of other people that are using measures that are something like it. But we think that would be, I would actually argue, that a high priority and that there's some work to be done in thinking through it.

Timothy Ferris – Massachusetts General – Medical Director

I totally agree with you, Sarah, in connecting that comment to your last comment about the disease specific stuff. There are a few, a relatively short list of conditions for which there is an evidence-base that a patient having an action plan makes a difference. In adult, there's heart failure, COPD, and asthma, and in kids, it's asthma. I'm sure there are others, but those are the big ones that everyone talks about and knows about. So we might, as a placeholder for our tiger team, even though there aren't measures developed, we actually measure distribution of asthma action plans for kids. We've been actually measuring that for a long time. But it seems like maybe there isn't a standard measure for that. But there is, under the conditions here, there is an asthma action plan. It says currently proposed by beacon communities. It is a relatively easy thing to measure, the fact that you handed it to the patient. You printed it out from your EHR from a template and handed it to a patient is a pretty easy thing to measure. It's very HIT sensitive. Maybe we'll leave that as a placeholder for the group and keep that on the list as for a limited set of conditions having documented distribution of action plans, condition specific action plans to eligible patients.

Sarah Scholle – NCQA – Assistant Vice President, Research
I want to say, I agree with you about that, but I think that the development should also consider whether it's focused on a condition specific action plan, which is for the patient, versus a care summary, including an action plan, that is both for the patient and for the patient to use that summarizes their care in other places. My understanding is that some of your colleagues are using that somewhere in Boston. They've got a summary that for children with chronic conditions. The group that has a hard time with a condition specific group because there are so few children with any one condition, but that kind of visit summary, I think, would be a way to pull together the information.

The other concept is to try to see how does the information from all the different providers from referrals from other testing and care being provided, even in other sectors, how does that get incorporated into the treatment plan, as well as the patient's self-management goals. Just a friendly amendment: The evidence base for the action plan is clear. The question is, is there also an opportunity to sort of specify something for people with complex conditions that are using care in multiple settings should there also be something called a visit summary that pulls together information from multiple settings or a care plan, not a summary?

Timothy Ferris – Massachusetts General – Medical Director
I think that's great, Sarah. I would put that maybe under the heading of more aspirational since it is less defined in terms of what exactly it is and how exactly one would measure it.

Sarah Scholle – NCQA – Assistant Vice President, Research
I agree.

Timothy Ferris – Massachusetts General – Medical Director
Keep those on the list as two separate items of products from the tiger team, and I think it's fine for us to have products that are not fully baked, but because very specifically they fell into sub-domains that we felt were high priorities, and we didn't have anything else to go in them that we put them forward. Then I'm going to return to a comment that I heard Helen make, which is, I think, Helen, you suggested we could even look at the rest of the measures on our own and propose them. What I'm going to propose is that people e-mail me. If you could look through the rest of these, see what you think about proposing any. Creagh and I will go over what we did here today, and a way to visually display it so that we capture the discussion we had using the measures in the Gretzky Report.

I would propose that on our next call, and we're scheduled for just two calls here, so the next call, we would then look at both the product of our discussion here in terms of the prioritization. We would then look at the prioritization of the domains and the measures. Then we would spend time sort of thinking again about our prioritization of the measures, but also look at any measures that people e-mailed me and said, "Hey, Tim. What about these, including these four measures? I thought they looked promising for care coordination." Does that sound like a transition or a process that would work, keeping in mind that if you accept my proposal, we would probably be ending this call earlier than scheduled?

Daniel Green – CMS/HHS – Medical Director
Do you mean looking across all the different tabs on the bottom and picking measures from there? Is that what you're suggesting?

Timothy Ferris – Massachusetts General – Medical Director
That's what I'm suggesting.

Daniel Green – CMS/HHS – Medical Director
Obviously not just the ones that we've yet to do on this particular page, right?

Timothy Ferris – Massachusetts General – Medical Director
That's correct.

Daniel Green – CMS/HHS – Medical Director
That works for me.

Helen Burstin – NQF – Senior VP, Performance Measures
Me too. It might be helpful to think about whether the other measures fit any of those other domains or if people can think of some measure of continuity. Creagh, correct me if I'm wrong, but I think we're still at the measure concept level being okay just in terms of the proposed timeline going forward from ONC. If we come up with what seems like a really important measure concept … appropriate and timely followup, for example, just making this up, the complete followup of all abnormal labs, complete followup of abnormal mammograms, etc., for which we don't necessarily think there are measures. I still think it's important for us to also, as a committee, come forward with what are those important measure concepts. I think David really pushed that point home on our open, our broader call last week.

Timothy Ferris – Massachusetts General – Medical Director
I couldn't agree more. We should certainly spend some time on the next call doing maybe even a little bit of brainstorming around where we don't have measures under the sub-domains that we think are high priorities. I don't want to repeat what you just said. I totally agree.

Daniel Green – CMS/HHS – Medical Director
That's critical because there is discussion, of course, about looking at new avenues for measure development, so that's critical. Great point, Helen.

Helen Burstin – NQF – Senior VP, Performance Measures
Sure.

Timothy Ferris – Massachusetts General – Medical Director
With that, I think it sounds like we're in agreement. I might ask our host, unless there are further comments, to ask if there is anyone listening out there, and ask if they would like to make any comments on our work at this point, and then we would then close the meeting, unless I hear any further comments or objections. I'd then ask our host to open the lines.

Alison Gary – Altarum Institute – Communication Technologies Coordinator
Operator, do let us know if there are any comments from the public.

Operator
There are no comments at this time.

Timothy Ferris – Massachusetts General – Medical Director
Can we know, is anyone listening?

Operator
Yes, sir. We do have members of the public listening in today.

Timothy Ferris – Massachusetts General – Medical Director
That's wonderful. I want to thank all the committee members and the tiger team members. This is my first tiger team, by the way, so it's very exciting. Creagh, we will be back in touch with you. We will send out the product of this call to you all prior to the next call. Do you have the date and time of the next call, Creagh?

Creagh Milford – ONC
Yes. It's next Wednesday, which would be the 13th. It'll be the same timeframe, 2:00 to 5:00.

Timothy Ferris – Massachusetts General – Medical Director
I think, based on our work today, I think that should be enough time for us to complete our work and report back. I do think we're going to want to spend some time. I think the simpler task will be the prioritization of the measures. The harder task this last discussion that we just had that Helen brought up, which is, given some of the concepts that we would like to measure, what are our initial thoughts about the importance of concepts within care coordination for which we didn't have measures, but we really think there should be some. If there are no further comments, thank you all for joining us.

Helen Burstin – NQF – Senior VP, Performance Measures
Great.

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research
Tim, thanks for coordinating the call. You did a great job. This is Laura.

Helen Burstin – NQF – Senior VP, Performance Measures
Yes. Have a great weekend.